(2) The 2-year filing limit for retroactive claims for Medicaid expenditures does not apply. A downward adjustment is not considered a retroactive claim but rather a reclaiming of costs previously claimed.

(d) *Expiration of 1-year recovery period.* If an overpayment has not been determined uncollectable in accordance with the requirements of § 433.318 of this subpart at the end of the 1-year period following discovery of the overpayment, the agency must refund the Federal share of the overpayment to CMS in accordance with the procedures specified in paragraph (a) of this section.

(e) *Court-approved discharge of bankruptcy.* If the State recovers any portion of an overpayment under a court-approved discharge of bankruptcy, the agency must refund to CMS the Federal share of the overpayment amount collected on the next quarterly expenditure report that is due to CMS for the period that includes the date on which the collection occurs.

(f) *Bankruptcy petition denied.* If a provider's petition for bankruptcy is denied in Federal court, the agency must credit CMS with the Federal share of the overpayment on the later of—

(1) The Form CMS–64 submission due to CMS immediately following the date of the decision of the court; or

(2) The Form CMS–64 submission for the quarter in which the 1-year period following discovery of the overpayment ends.

(g) *Reclaim of refunds.* (1) If a provider is determined bankrupt or out of business under this section after the 1-year period following discovery of the overpayment ends and the State has not been able to make complete recovery, the agency may reclaim the amount of the Federal share of any unrecovered overpayment amount previously refunded to CMS. CMS allows the reclaim of a refund by the agency if the agency submits to CMS documentation that it has made reasonable efforts to obtain recovery.

(2) If the agency reclaims a refund of the Federal share of an overpayment—

(i) In bankruptcy cases, the agency must submit to CMS a statement of its efforts to recover the overpayment during the period before the petition for bankruptcy was filed; and

(ii) In out-of-business cases, the agency must submit to CMS a statement of its efforts to locate the provider and its assets and to recover the overpayment during any period before the provider is found to be out of business in accordance with § 433.318.

(h) *Supporting reports.* The agency must report the following information to support each Quarterly Statement of Expenditures Form CMS–64:

(1) Amounts of overpayments not collected during the quarter but refunded because of the expiration of the 1-year period following discovery;

(2) Upward and downward adjustments to amounts credited in previous quarters;

(3) Amounts of overpayments collected under court-approved discharges of bankruptcy;

(4) Amounts of previously reported overpayments to providers certified as bankrupt or out of business during the quarter; and

(5) Amounts of overpayments previously credited and reclaimed by the State.

[54 FR 5460, Feb. 3, 1989, as amended at 77 FR 31512, May 29, 2012]

§ 433.322 Maintenance of Records.

The Medicaid agency must maintain a separate record of all overpayment activities for each provider in a manner that satisfies the retention and access requirements of 45 CFR 75.361 through 75.370.

[77 FR 31512, May 29, 2012, as amended at 81 FR 3011, Jan. 20, 2016]

PART 434—CONTRACTS

Subpart A—General Provisions

Sec.

Subpart B—Contracts with Fiscal Agents and Private Nonmedical Institutions

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

SOURCE: 48 FR 54020, Nov. 30, 1983, unless otherwise noted.

Subpart A—General Provisions

§ 434.1 Basis and scope.

(a) *Statutory basis.* This part is based on section 1902(a)(4) of the Act, which requires that the State plan provide for methods of administration that the Secretary finds necessary for the proper and efficient operation of the plan.

(b) *Scope.* This part sets forth the requirements for contracts with certain organizations for furnishing Medicaid services or processing or paying Medicaid claims, or enchancing the agency's capability for effective administration of the program.

[48 FR 54020, Nov. 30, 1983; 48 FR 55128, Dec. 9, 1983, as amended at 67 FR 41095, June 14, 2002]

§ 434.2 Definitions.

As used in this part, unless the context indicates otherwise—

Fiscal agent means an entity that processes or pays vendor claims for the agency.

Health care projects grant center means an entity that—

(a) Is supported in whole or in part by Federal project grant financial assistance; and

(b) Provides or arranges for medical services to beneficiaries.

Private nonmedical institution means an institution (such as a child-care facility or a maternity home) that—

(a) Is not, as a matter of regular business, a health insuring organization or a community health care center;

(b) Provides medical care to its residents through contracts or other arrangements with medical providers; and

(c) Receives capitation payments from the Medicaid agency, under a nonrisk contract, for its residents who are eligible for Medicaid.

Professional management service or consultant firm means a firm that performs management services such as auditing or staff training, or carries out studies or provides consultation aimed at improving State Medicaid operations, for example, with respect to reimbursement formulas or accounting systems.

[48 FR 54020, Nov. 30, 1983; 48 FR 55128, Dec. 9, 1983, as amended at 52 FR 22322, June 11, 1987; 55 FR 51295, Dec. 13, 1990; 67 FR 41095, June 14, 2002]

§ 434.4 State plan requirement.

If the State plan provides for contracts of the types covered by this part, the plan must also provide for meeting the applicable requirements of this part.

§ 434.6 General requirements for all contracts and subcontracts.

(a) *Contracts.* All contracts under this part must include all of the following:

(1) Include provisions that define a sound and complete procurement contract, as required by 45 CFR part 75.

(2) Identify the population covered by the contract.

(3) Specify any procedures for enrollment or reenrollment of the covered population.

(4) Specify the amount, duration, and scope of medical services to be provided or paid for.

(5) Provide that the agency and HHS may evaluate through inspection or other means, the quality, appropriateness and timeliness of services performed under the contract.

(6) Specify procedures and criteria for terminating the contract, including a requirement that the contractor promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.

(7) Provide that the contractor maintains an appropriate record system for services to enrolled beneficiaries.

(8) Provide that the contractor safeguards information about beneficiaries as required by part 431, subpart F of this chapter.

(9) Specify any activities to be performed by the contractor that are related to third party liability requirements in part 433, subpart D of this chapter.

(10) Specify which functions may be subcontracted.

(11) Provide that any subcontracts meet the requirements of paragraph (b) of this section.

(12) Specify the following:

(i) No payment will be made by the contractor to a provider for provider-preventable conditions, as identified in the State plan.

(ii) The contractor will require that all providers agree to comply with the reporting requirements in § 447.26(d) of this subchapter as a condition of payment from the contractor.

(iii) The contractor will comply with such reporting requirements to the extent the contractor directly furnishes services.

(b) *Subcontracts.* All subcontracts must be in writing and fulfill the requirements of this part that are appropriate to the service or activity delegated under the subcontract.

(c) *Continued responsibility of contractor.* No subcontract terminates the legal responsibility of the contractor to the agency to assure that all activities under the contract are carried out.

[48 FR 54020, Nov. 30, 1983, as amended at 67 FR 41095, June 14, 2002; 76 FR 32837, June 6, 2011; 81 FR 3011, Jan. 20, 2016]

Subpart B—Contracts with Fiscal Agents and Private Nonmedical Institutions

§ 434.10 Contracts with fiscal agents.

Contracts with fiscal agents must—

(a) Meet the requirements of § 434.6;

(b) Include termination procedures that require the contractors to supply promptly all material necessary for continued operation of payment and related systems. This material includes—

(1) Computer programs;

(2) Data files;

(3) User and operation manuals, and other documentation;

(4) System and program documentation; and

(5) Training programs for Medicaid agency staff, their agents or designated representatives in the operation and maintenance of the system;

(c) Offer to the State one or both of the following options, if the fiscal agent or the fiscal agent's subcontractor has a proprietary right to material specified in paragraph (b) of this section:

(1) Purchasing the material; or

(2) Purchasing the use of the material through leasing or other means; and

(d) State that payment to providers will be made in accordance with part 447 of this chapter.

§ 434.12 Contracts with private nonmedical institutions.

Contracts with private nonmedical institutions must—

(a) Meet the requirements of § 434.6;

(b) Specify a capitation fee based on the cost of the services provided, in accordance with the reimbursement requirements prescribed in part 447 of this chapter; and

(c) Specify when the capitation fee must be paid.

§ 434.14 [Reserved]

Subpart C [Reserved]

Subpart D—Contracts With Health Insuring Organizations

§ 434.40 Contract requirements.

(a) Contracts with health insuring organizations that are not subject to the requirements in section 1903(m)(2)(A) must:

(1) Meet the general requirements for all contracts and subcontracts specified in § 434.6;

(2) Specify that the contractor assumes at least part of the underwriting risk and;

(i) If the contractor assumes the full underwriting risk, specify that payment of the capitation fees to the contractor during the contract period constitutes full payment by the agency for

the cost of medical services provided under the contract;

(ii) If the contractor assumes less than the full underwriting risk, specify how the risk is apportioned between the agency and the contractor;

(3) Specify whether the contractor returns to the agency part of any savings remaining after the allowable costs are deducted from the capitations fees, and if savings are returned, the apportionment between agency and the contractor; and

(4) Specify the extent, if any, to which the contractor may obtain reinsurance of a portion of the underwriting risk.

(b) The contract must—

(1) Specify that the capitation fee will not exceed the limits set forth under part 447 of this chapter.

(2) Specify that, except as permitted under paragraph (b) of this section, the capitation fee paid on behalf of each beneficiary may not be renegotiated—

(i) During the contract period if the contract period is 1 year or less; or

(ii) More often than annually if the contract period is for more than 1 year.

(3) Specify that the capitation fee will not include any amount for recoupment of any specific losses suffered by the contractor for risks assumed under the same contract or a prior contract with the agency; and

(4) Specify the actuarial basis for computation of the capitation fee.

(c) The capitation fee may be renegotiated more frequently than annually for beneficiaries who are not enrolled at the time of renegotiation or if the renegotiation is required by changes in Federal or State law.

[55 FR 51295, Dec. 13, 1990]

Subpart E [Reserved]

Subpart F—Federal Financial Participation

SOURCE: 48 FR 54020, Nov. 20, 1983, unless otherwise noted. Redesignated at 55 FR 51295, Dec. 13, 1990.

§ 434.70 Conditions for Federal Financial Participation (FFP).

(a) *Basic requirements.* FFP is available only for periods during which the contract—

(1) Meets the requirements of this part;

(2) Meets the applicable requirements of 45 CFR part 75; and

(3) Is in effect.

(b) *Basis for withholding.* CMS may withhold FFP for any period during which the State fails to meet the State plan requirements of this part.

[67 FR 41095, June 14, 2002, as amended at 81 FR 3011, Jan. 20, 2016]

§ 434.76 Costs under fiscal agent contracts.

Under each contract with a fiscal agent—

(a) The amount paid to the provider of medical services is a medical assistance cost; and

(b) The amount paid to the contractor for performing the agreed-upon functions is an administrative cost.

§ 434.78 Right to reconsideration of disallowance.

A Medicaid agency dissatisfied with a disallowance of FFP under this subpart may request and will be granted reconsideration in accordance with 45 CFR part 16.

PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA

Subpart A—General Provisions and Definitions

Sec.

Subpart B—Mandatory Coverage

MANDATORY COVERAGE OF FAMILIES AND CHILDREN